PARITY FOR MENTAL ILLNESS, DISPARITY FOR THE MENTAL PATIENT

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The core concept of mental illness-to which the vast majority of psychiatrists and the public adhere-is that diseases of the mind are diseases of the brain; in other words, that mental diseases and brain diseases are the same kinds of diseases.[1] It is now widely accepted that "the overwhelming weight of medical research has demonstrated that mental illnesses are biologically based".[2] The equating of mental disease with brain disease, supported by the authority of a large body of neuroscience literature, is used to rationalise the drug treatment of mental illness and justify the demand for parity in insurance coverage for medical and mental disorders.

Reflecting the influence of these ideas and their implications, on Sept 26, 1997, President Clinton signed the Mental Health Parity Act of 1996 (PL 104-204), which took effect on Jan 1, 1998). "This landmark law", according to the National Alliance for the Mentally Ill (NAMI), "begins the process of ending the long-held practice of providing less insurance coverage for mental illnesses, or brain disorders, than is provided for equally serious physical disorders". (See the NAMI website- http://www.nami.org .)

Many states have enacted similar legislation.[2] Congress enacted, 7 years earlier, the Patient Self-Determination Act, another important piece of legislation with potentially far-reaching implications for mental patients.

It has apparently gone unnoticed that the rhetoric of parity in insurance status for patients with medical or mental illness is inconsistent with the reality of disparity in their legal status. This disparity is usually justified on the ground that medical diseases, unlike mental diseases, are unlikely to impair the patient's competence to elect or reject treatment. Patients with sarcoma are assumed to remain in possession of their mental faculties, but patients with schizophrenia are not. Thus, medical patients are treated as contracting moral agents, and medical hospitals and physicians are never accused of imprisoning them. Mental patients, however, are commonly treated as if they are minors or unconscious, and mental hospitals and psychiatrists are often accused of imprisoning them.[3]

Note that the truth or falsity of the claim that mental diseases are brain diseases is largely irrelevant to the disparity in legal status between the patient with psychiatric illness and the patient with neurological illness. Before World War II, when neurosyphilis was still common, most patients with paresis (general paralysis of the insane)-unlike most patients with other neurological ailments, such as Parkinsonism and multiple sclerosis-were confined in mental hospitals against their will.There was a good reason for this policy. Patients with paresis, like other "insane" people, commonly exhibited "disordered" thoughts, feelings, and behaviours, whereas most patients with other brain diseases did not. In short, mental patients (the "mad" or "insane") were confined against their will primarily because they misbehaved, not because they were sick. This continues to be the case.

The contention that confining people against their will is an accepted part of the mental hospital's social function is starkly illustrated by the 1997 Supreme Court ruling in Kansas v

Leroy Hendricks (No 95-1649) upholding a law that "states have a right to use psychiatric hospitals to confine certain sex offenders once they have completed their prison terms, even if those offenders do not meet mental illness commitment criteria".[4,5] Despite the characterisation of this ruling as an "abuse" of the mental health system by Psychiatric News, the American Psychiatric Association's official newspaper,[6] traditional social-psychiatric custom leads directly to such abuses. As the diagnosis of bodily illness justifies a physician's admission of a willing patient to the hospital, so the diagnosis of mental illness justifies a judge's (and a psychiatrist's) admission of an unwilling patient to a mental hospital. Failure to acknowledge this fact precludes genuine reforms in psychiatric policy.

The Patient Self-Determination Act makes it mandatory for healthcare providers receiving Medicare or Medicaid payments to "inform patients of their existing rights under state law to refuse treatment and prepare advance directives".[7] The Act requires healthcare providers in hospitals and other healthcare settings:

- To develop written policies concerning advance directives;
- To ask all new patients whether they have prepared an advance directive and to include this information in the patient's chart;
- To give patients written materials describing the facility's policies on advance directives and the patient's right (under applicable state law) to prepare such a document; and
- To educate staff and the community about advance directives.[8]

The mandate of the Act reflects the US political commitment to the value of the patient's autonomy as an integral part of the right to personal liberty. Although nothing in the Act suggests that the term "patient" does not include those treated by psychiatrists, prevailing mental health practices clearly fail to comply with the mandates-for example, involuntary psychiatric hospitalisation, and involuntary drug treatment of mental patients living in psychiatric facilities as well as the community.

The treatment of people without their consent, and even against their will, happens far more often with mental patients than with medical patients. Rare but dramatic dilemmas of involuntary treatment involving patients on life support, such as the much-publicised case of Nancy Cruzan,[9] capture the interest of the public. Most people can imagine themselves on life support against their will. By contrast, routine cases of involuntary treatment-typically involving the admission to hospital of people who disturb the peace-appear uncontroversial and hold little interest for the public. Most people either cannot see themselves in such a predicament or believe that, in such a situation, medical judgment ought to over-ride the patient's choice. These reactions reflect the intuitive understanding, albeit unarticulated, experienced by most people who feel that there really is a difference between medical and mental disease.

I hope that the increasing emphasis on patient responsibility and self-determination in medicine will have a knock-on effect on patient responsibility and self-determination in psychiatry. Indeed, I believe that the so-called medical model of mental illness holds out more promise for clarifying the mental patients' legal status than for understanding their malady. In any case, we have to confront the marked disparity in legal status between these two kinds of patients.

The evidence that psychiatric practices fail to conform to the requirements of the Patient Self-Determination Act is so abundant that the assertion hardly requires documentation. A single example should suffice. Investigators studied about 350 admissions to three acute psychiatric inpatient units in Virginia. 45 of the patients tried to refuse treatment. None succeeded: "Psychiatrists exercised their discretion to promptly treat all patients who refused treatment. Nonetheless, these patients suffered more morbidity than compliant patients. This study suggests that the negative sequelae of an in hospital treatment refusal cannot be eliminated by rapid treatment".[10] The investigators candidly acknowledge that "refusers were prescribed higher doses of antipsychotic medications than were compliant patients". Patients who refused treatment, according to this study, "had negative attitudes toward past, present, and future treatment at the time of admission"; it was felt that such attitudes may be "generated by prior coercive treatment".

The dilemmas that mental patients pose for themselves, their families, and society can be resolved if the familiar advance directive or "living will" is adapted to the circumstances of psychiatric patients and their carers. I proposed such an advance psychiatric directive-or, as I called it, "psychiatric will"-in 1982, crafting it especially for the needs of mental patients who face the prospect of future involuntary treatment.[11] The intent of the directive was to transcend the problems created by psychiatric crises or emergencies-situations in which the patients' involuntary treatment is justified by their being deemed dangerous to themselves or others.

Modeled on the last will that comes into force after death, the psychiatric will becomes operative only after the person's legal status has undergone the change he or she anticipates. As the last will becomes effective only after the testator is officially declared dead, the psychiatric will would become effective only after the person was officially declared a mental patient (dangerous to himself or others). Executing such a document would be of special interest to individuals who have undergone an episode of involuntary psychiatric treatment; they would have first-hand experience of the interventions they might want to request or reject in the future, should they be deemed to require psychiatric care. Like the last will, the psychiatric will would be valid only if executed by people considered legally competent at the time of its signing. This criterion is met, by definition, by individuals who have been discharged from psychiatric hospitals, because they are deemed capable of living on their own. Generally, mental patients not declared legally incompetent are covered because, in the USA, adults are presumed to be competent until declared incompetent, just as defendants are presumed to be innocent until proven guilty. So far, the idea of a psychiatric will has aroused more interest in Europe, especially Germany, than it has in the USA.

Some may object that if people who are committable by current criteria were left at liberty, because that is what they requested in their psychiatric will, they might harm themselves or others, imposing financial and personal costs on families, insurance companies, or the government. Although this is true, involuntary psychiatric interventions also entail significant financial and personal costs, and it is not at all clear which option would be the costliest in the long run. In any case, in Anglo-American political philosophy, there is not supposed to be a price on the freedom of the individual. As for the possibility of such people harming others, their psychiatric will deals with this contingency by requesting that their "treatment" consist of the punishment prescribed by law for their particular offence.

Another objection, also stemming from the fear of the mental patient's dangerousness, might run like this. When a medically ill person—such as one with a progressive brain tumour loses his “mind," it is reasonable to respect his advance request that he be given no further treatment since his choice harms only himself. However, when a mentally ill person, such as one with schizophrenia, loses his "mind", many people feel it is unreasonable to respect his advance request that he be given no further treatment because his choice may harm others as well. This misgiving is intrinsic to our concept of mental illness. We do not know, however, whether so-called mental patients would commit more or less violence against others if those who elect to be punished for legal transgression were to be "treated" by the legal sanctions they prefer rather than by the psychiatric sanctions they reject.

Curiously, writers on advance directives rarely consider the situation of psychiatric patients; when they do consider it, it is to promote the patients' consent to treatment rather than to protect their right to refuse it. For example, a recent treatise by an attorney on the mental patient's right to refuse treatment makes no reference to the Patient Self-Determination Act or to the psychiatric will. The attorney takes the view that when the psychiatrist's decision is to treat, the patient's refusal is suspect: "When the objection is to a therapeutic intervention-hospitalization or conventional treatment-recommended by the patient's therapists, there also may be reason to at least question whether the refusal of such treatment might be anti-therapeutic and inconsistent with their welfare".[12] He goes on to say that the use of such instruments by mental patients may be "therapeutically advantageous".

Such prejudgment destroys the usefulness of the advance directive as a device for protecting the mental patient's right to self-determination. In psychiatry, unlike in other medical specialties, tradition sanctions the use of involuntary treatment. Hence, the principal use of advanced directives in psychiatry must be to help patients to avoid unwanted interventions. In a setting where enlightened voices claim that patients diagnosed as mentally ill ought to be treated like patients diagnosed as medically ill, and where laws guarantee "parity" with respect to insurance coverage, differential treatment of the two groups with respect to their right to refuse treatment is particularly troubling. We must beware lest these latest efforts at psychiatric reform result in greater parity between psychiatric and non-psychiatric physicians, but greater disparity between psychiatric and non-psychiatric patients.

Adoption of an advance mental-health directive or psychiatric will would help patients, physicians, and lawyers alike to cut psychiatry's Gordian knot-namely, the conflation of (mental) illness and (legal) incompetence. The Patient Self-Determination Act requires that the law afford the same rights to accept or reject treatment to the competent medical patient and to the competent (ex)mental patient. The psychiatric will, supported by the proper application of the Act to psychiatry, would thus protect mental patients from involuntary treatment in the event that, at some future time, they are deemed to be in need of such treatment, but, because of (mental) illness, are thought to be unable to make sound decisions about their own welfare. (If such persons break the law, they ought to be charged with a crime and tried for it; if not, they ought to be left alone.) Psychiatric practice would then conform to the requirements of the Act, and Americans, as patients as well as citizens, would be guaranteed equal protection under the law.

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